



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

APPLICATION FOR CRIME VICTIMS' COMPENSATION

FOR OFFICE USE ONLY

Claim No. _____

INSTRUCTIONS: 1. Type or Print clearly in ink.
2. Last page of this form must be signed by claimant and notarized.
3. If victim is a minor or an incompetent person, application **MUST** be made by a parent or guardian.
4. If a question is NOT APPLICABLE, answer with N/A.

MAILING ADDRESS CRIME VICTIMS' COMPENSATION PROGRAM P.O. BOX 3001, JEFFERSON CITY, MISSOURI 65102-3001	TELEPHONE NUMBER (573) 526-6006 1-800-347-6881	RELAY MISSOURI 1-800-735-2966 (TDD) 1-800-735-2466 (VOICE)
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How did you find out about the Crime Victims' Compensation Program?
☐ Police ☐ Victim Assistance Program ☐ Prosecutor ☐ Funeral Home ☐ Friend/Family
☐ Hospital ☐ Public Service Announcement ☐ Poster/Brochure ☐ Collection Agency

SECTION I PRIMARY VICTIM INFORMATION

Name of Victim (<i>Last, First and Middle</i>)				Social Security Number	
Current Street Address		City		State	Zip Code
Home Telephone Number	Work Telephone Number	Country of Birth - National Origin*		Is Victim Deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthdate	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Race Ethnic (<i>Check One</i>)* <input type="checkbox"/> 1. White <input type="checkbox"/> 2. Black <input type="checkbox"/> 7. Other: _____ <input type="checkbox"/> 3. Hispanic <input type="checkbox"/> 4. American Indian/Alaskan Native <input type="checkbox"/> 5. Asian Pacific Islander <input type="checkbox"/> 6. Race Ethnic (optional)			Handicapped Prior to Crime* <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Explain</i>)		
Date Crime Occurred					
Has the victim been convicted of two felonies within the past ten (10) years? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain : _____					

SECTION II CLAIMANT INFORMATION Complete this section if someone other than the victim is filing claim (i.e. parent/legal guardian).

Name of Claimant (<i>Last, First and Middle</i>)				Social Security Number	
Street Address		City		State	Zip Code
Relationship to Victim	Was victim living with you at the time of the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Telephone Number		Work Telephone Number	
Birthdate	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		

SECTION III OTHER COMPENSABLE VICTIM *CHAPTER 595 (If more than one, use additional sheet.)

Name of other compensable victim (<i>Last, First and Middle</i>)				Social Security Number	
Current Street Address		City		State	Zip Code
Home/Work Telephone Number	Relationship to Primary Victim	Country of Birth - National Origin*		Handicapped Prior to Crime* <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthdate	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Race Ethnic (<i>Check One</i>)* <input type="checkbox"/> 1. White <input type="checkbox"/> 3. Hispanic <input type="checkbox"/> 5. Asian Pacific Islander <input type="checkbox"/> 7. Other: _____ <input type="checkbox"/> 2. Black <input type="checkbox"/> 4. American Indian/Alaskan Native <input type="checkbox"/> 6. Race Ethnic (optional)					
Was the other compensable victim living with the primary victim at the time of the crime? (Chapter 595) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____					

Has the other compensable victim been convicted of two felonies within the past ten (10) years? ☐ Yes ☐ No If yes, explain: _____

* This information is requested solely for compliance with Federal Civil Rights under Section 1407(c) of the Victims of Crimes Act of 1984. It will be used only for statistical purposes.

NOTE APPLICATION MUST BE SIGNED AND NOTARIZED ON BACK PAGE. PHOTOCOPIES ARE NOT ACCEPTABLE.

SECTION IV CRIME INFORMATION						Was a Police Report Filed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Type of Crime: <input type="checkbox"/> Assault <input type="checkbox"/> Sexual Offense <input type="checkbox"/> Homicide <input type="checkbox"/> DWI* <input type="checkbox"/> Involuntary Manslaughter* <input type="checkbox"/> Robbery With Injury <input type="checkbox"/> Hit & Run* <input type="checkbox"/> Other (Explain:) _____ (*Be Sure To Complete Insurance Under Section VII)								
Brief Description of Crime: _____ _____ _____								
Date Crime Occurred		Date Crime Was Reported		Has Arrest Been Made? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have Charges Been Filed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Place of Crime: Street Address			City/State			County		
Name and Address of Police Department				Name of Investigating Officer(s)				
Who Committed the Crime? (If Known)			Police Report Number			Docket Number		
Did victim know the person who committed the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, in what way? _____ Was victim related to the person who committed the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, in what way? _____ Was victim living in the same household as the offender at the time of the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, is victim still living in same house as offender? _____								
SECTION V MEDICAL (INCLUDING PSYCHOLOGICAL) EXPENSES Enter below all expenses for service rendered as a result of this crime. (Attach all bills available)						Will there be more bills? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Doctor, Hospital or Other Provider of Service		Account Number	Street Address			City	State	Zip Code
SECTION VI FUNERAL EXPENSES (Attach Copy of Death Certificate and Funeral Bill)								
Will dependent(s) receive funeral benefits from the following?								
Social Security \$		Workers' Compensation \$		Life Insurance \$		Other (Specify) \$		
Name of Funeral Home			Street Address					
City			State	Zip Code		Amount of Funeral and Burial Expenses \$		
Have Burial Expenses Been Paid? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, by whom?				Relationship to Victim		
City			State		Zip Code			
Will dependent(s) receive any accident or life insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:								
Name of Beneficiary			Street Address					
City			State	Zip Code		Phone (If Known)		

SECTION VII INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION				
Indicate below if any sources are paying or will pay any of above expenses.				
Source Type: <input type="checkbox"/> Health Insurance/HMO/PPO <input type="checkbox"/> Veterans Administration <input type="checkbox"/> Armed Services (CHAMPUS) <input type="checkbox"/> Life Insurance <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid No. _____ <input type="checkbox"/> Workers' Compensation No. _____				
Provide the following information for each source. (If more than one source is paying, provide additional information on separate sheet)				
Insurance Name			Policy Number	
Street Address		City	State	Zip Code
Name of Policy Holder		Social Security Number of Policy Holder		Effective Date of Policy/Coverage
AUTO INSURANCE INFORMATION - COMPLETE THIS SECTION ONLY FOR MOTOR VEHICLE CLAIM				
Does convicted operator have liability insurance coverage on auto? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, enter name of carrier and policy limits.		
Street Address	City	State	Zip Code	Policy Number
Does the victim have uninsured motorist coverage on auto? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, enter name of carrier and policy limits.		
Street Address	City	State	Zip Code	Policy Number
Has settlement been made with carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, which one? (Attach copy of settlement)		
SECTION VIII WAGE LOSS/LOSS OF SUPPORT (Fill out only if victim was employed at the time of the crime and a loss is being claimed)				
Was victim employed at time of crime? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is victim applying for lost wages? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is a dependent applying for loss of support? <input type="checkbox"/> Yes <input type="checkbox"/> No
Victim's Employer (at time of crime)			Telephone Number	
Victim's Employer Address		City	State	Zip Code
If victim was self-employed, submit copies of signed Federal Income Tax returns from the year of the crime and the year preceding the crime.				
Victim's net (take home) earnings or income at time of crime (including tips and bonuses) if time loss or loss of support benefits are claimed: \$ _____ per week.				
Date left work due to crime: (Month, Day, Year) _____				
Date returned to work: (Month, Day, Year) _____				
Days off for which victim received compensation in the form of accrued sick/vacation leave ➡				
Was the crime work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, has the victim applied for Workers' Compensation or other employment benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, please describe. _____ _____				
Are you receiving or have you received accident or disability benefits from your employer as a result of this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, please describe. _____ _____				
SECTION IX OTHER INFORMATION				
Is the victim or claimant considering a civil action against the offender or some other third party for damages claimed herein? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, please provide the name and mailing address of attorney who will handle the civil action: _____ _____				
RESTITUTION				
If the court has ordered the offender to make restitution to you (pay you back), complete the following:				
Restitution Order Date _____		Court _____	Amount \$ _____	
Judge _____		How Is It To Be Paid? _____		

ATTORNEY INFORMATION

It is not necessary to retain an attorney; however, if claimant wishes to be represented by an attorney in applying for benefits under Crime Victims' Compensation, please complete the following. Attorneys are entitled to up to 15% of any award issued. The attorney will need to file an entry of appearance.

Attorney's Name (*Last, First, MI*)

Telephone Number

Address

City

State

Zip Code

Signature of Attorney (if representing claimant in Crime Victims' claim)

Date

AUTHORIZATION FOR RELEASE OF INFORMATION TO CONDUCT AN INVESTIGATION, TO MAKE PAYMENTS DIRECTLY TO SUPPLIERS AND ASSIGNMENT OF SUBROGATION RIGHTS

I give permission to any attorney, hospital, funeral home, doctor, law enforcement agency, insurance company, employer, welfare or social agency, or any federal, state or local government agency to release all records and information that will help the Missouri Crime Victims' Compensation Unit to process my claim for compensation, to allow copies of such records to be made and to answer any questions made by or on behalf of the Missouri Crime Victims' Compensation Unit.

I understand that after receiving this form, the Missouri Crime Victims' Compensation Unit will investigate the truth of the information provided as well as other matters regarding this claim; and I consent to such investigation. This authorization is valid for two years from the date given below.

I acknowledge and agree that all or any part of any compensation awarded may be paid directly to any supplier of goods or services on my behalf.

I further acknowledge and agree that the State of Missouri is subrogated, to the extent of any compensation awarded to me, to all the claimant's rights to recover benefits or advantages for economic loss from a source which is, or if readily available to the victim or claimant would be, a collateral source, and I hereby assign such rights to the State of Missouri so that it may protect its subrogation rights, and agree to assist the state in pursuing its subrogation rights.

I agree to notify the Division if I retain an attorney to represent me in a lawsuit related to this crime. I also agree to notify the Division: 1) in the event I receive restitution payments from the offender, or 2) in the event I initiate any legal proceeding or negotiations to recover damages related to the crime upon which this claim is based.

I certify that I have read and understand the statements above; and that the information I have given is true and correct to the best of my knowledge and belief and that these benefits will be denied if any such statements are not true.

Signature of Claimant

Date

(If the victim is under 18 years of age, this application must be signed by the parent or legal guardian whose name appears in "Section II Claimant Information").

STATE OF MISSOURI**COUNTY OF**

SS

On this _____ day of _____, 20____, before me personally appeared _____, *(Name of Claimant)*

to me known to be the person described in and who executed the foregoing Crime Victims' Compensation Application and acknowledged that _____ executed the same as _____ free act and deed. And said claimant declares that the information *(S/He)* *(His/Her)* provided is true and correct to the best of _____ knowledge. *(His/Her)*

Subscribed and sworn to before me at my office in _____ the day and year first *(Notary's Office Location)* above written.

(Notary Seal)

Notary Signature

My commission expires: _____